U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 27 January 2005

CASE NO.: 2003-BLA-5894

In the Matter of

DALEY WELLS, o/b/o
JAMES F. WELLS (Deceased),
Claimant

v.

BUFFALO MINING COMPANY,
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

Appearances:

Andrew Delph, Esq.,
For the Claimant

Ashley Harmon, Esq.,
For the Employer

Before: RICHARD A. MORGAN
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS

This proceeding arises from a miner's duplicate claim for benefits, under the Black Lung Benefits Act, 30 U.S.C. § 901 *et seq*., as amended ("Act"), filed on September 27, 2001, respectively. The Act and implementing regulations, 20 C.F.R. parts 410, 718, and 727 (Regulations), provide compensation and other benefits to:

1. Living coal miners who are totally disabled due to pneumoconiosis and their dependents;
2. Surviving dependents of coal miners whose death was due to pneumoconiosis; and,
3. Surviving dependents of coal miners who were totally disabled due to pneumoconiosis at the time of their death.

The Act and Regulations define pneumoconiosis ("black lung disease" or "coal worker's pneumoconiosis" ("CWP")) as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments arising out of coal mine employment.

PROCEDURAL HISTORY

The miner filed his first claim for benefits on January 1, 1970. (Director's Exhibit ("DX") 1). The claim was denied by the district director because the evidence failed to establish the element of entitlement that Mr. Wells had coal workers' pneumoconiosis. The miner did not seek further appeal of this determination.

The miner filed a second claim for benefits on June 13, 1984. In a July 20, 1987 Decision and Order, Administrative Law Judge Giannasi found that the miner had pneumoconiosis, but was not totally disabled due to pneumoconiosis. Thus, benefits were denied. This claim was before the Benefits Review Board and the Fourth Circuit Court of Appeals on numerous occasions. On August 6, 1996, the Fourth Circuit Court of Appeals affirmed the denial of benefits. Thereafter, the miner sought modification of the Administrative Law Judge's decision. Modification was denied on May 13, 1998. (DX 1).

Mr. Wells filed a third claim for benefits on March 27, 2000. On September 6, 2000, this claim was denied by the Department of Labor because the evidence failed to establish the element of entitlement that Mr. Wells was totally disabled due to pneumoconiosis. Mr. Wells did not seek further appeal of this decision. (DX 2).

The current claim for benefits was filed on September 27, 2001. (DX 3). On December 4, 2002, the District Director issued a Proposed Decision and Order denying benefits. (DX 25). The December 4, 2002 Proposed Decision and Order was mailed to the wrong address, and, as such, Claimant never received the proposed decision. Due to the problems in service, the District Director issued a Revised Proposed Decision and Order denying benefits, dated January 22, 2003. The claim was denied by the District Director because the evidence failed to establish the element of entitlement that Mr. Wells was totally disabled due to pneumoconiosis. (DX 28). On February 13, 2003, the claimant requested a hearing before an administrative law judge. (DX 30). Mr. Wells passed away on March 7, 2003. (DX 33). On May 19, 2003, the case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Program (OWCP) for a formal hearing. The case was assigned to Administrative Law Judge Lesniak. Judge Lesniak continued the case, at Claimant's request, for additional time to find legal representation. I was assigned the case on February 3, 2004.

On June 30, 2004, I held a hearing in Charleston, West Virginia, at which the claimant and employer were represented by counsel.[1] No appearance was entered for the Director, Office of Workman Compensation Programs (OWCP). The parties were afforded the full opportunity to

[1] Under *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1998)(en banc), the location of a miner's last coal mine employment, i.e., here the state in which the hearing was held, is determinative of the circuit court's jurisdiction. Under *Kopp v. Director, OWCP*, 877 F.2d 307, 309 (4th Cir. 1989), the area the miner was exposed to coal dust, i.e., here the state in which the hearing was held, is determinative of the circuit court's jurisdiction.

present evidence and argument. Claimant's exhibits ("CX") 1-2, Director's exhibits ("DX") 1-37, and Employer's exhibits ("EX") 1-10 were admitted into the record.

At the June 30, 2004 hearing, Claimant's counsel's request to have Dr. Perper deposed post-hearing was granted by the undersigned. Dr. Perper's deposition was submitted to the Court on August 26, 2004. It is hereby admitted into the record and marked as Claimant's exhibit 3.

On September 22, 2004, the undersigned issued an Order Denying Employer's Request to Strike Dr. Perper's Report and Deposition Testimony, Granting Employer's Request to Submit Medical Literature, and Granting Employer's Request to Submit Additional Rehabilitative Report by Dr. Naeye in response to Employer's Motion to Strike Dr. Perper's Report and Deposition. Employer's counsel was permitted to submit the medical articles relied on by Dr. Perper and ignored by Dr. Perper. On October 5, 2004, Employer's counsel submitted the following four articles to the Court:

1. "*Mortality from Lung Cancer in U.S. Coal Miners,*" Costellow, Ortmeyer, Morgan, American Journal of Public Health, Vol. 64, No. 3, 222-24 (1974);
2. "*Lung Cancer by Histologic Type in Coal Miners,*" Vallyathan, Green, Rodman, Boyd, Althouse; Archives of Pathology and Laboratory Medicine, Vol. 109, 419-423 (May 1995);
3. "*Epidemiologic Studies of Inorganic Dust-Related Lung Disease in the Netherlands,*" Meijers, Swaen, Van Vielt, Beorm; Experimental Lung Research, Vol. 16, 15-23 (1990); and
4. International Agency for Research on Cancer (IARC), World Health Organization, "*Summary Data and Reported Evaluation for Carcinogenicity of Coal Dust*," available http://www.cie.iarc.fr/htdocs/monographs/vol68/coal.htm (website checked Oct. 5, 2004).

These articles are hereby admitted into the record and marked as Employer's exhibit 11. Employer notes that articles 1 through 3 were referenced in Dr. Naeye's reports. The IARC statement was discussed during the depositions of Drs. Perper and Castle. As such, the undersigned reviewed such articles in conjunction with such physician opinions.

Employer's counsel submitted a closing argument post-hearing, dated October 22, 2004. No closing argument was submitted by Claimant's counsel.

ISSUES

I. Whether the miner had pneumoconiosis as defined by the Act and the Regulations?

II. Whether the miner's pneumoconiosis arose out of his coal mine employment?

III. Whether the miner was totally disabled?

IV. Whether the miner's disability was due to pneumoconiosis?

V. Whether there has been a change in an applicable element of entitlement upon which the order denying the prior claim became final?

FINDINGS OF FACT

I. Background

A. Coal Miner

The claimant was a coal miner, within the meaning of § 402(d) of the Act and § 725.202 of the Regulations, for at least 10 years. (DX 8 & 9).

B. Date of Filing[2]

The claimant filed his claim for benefits, under the Act, on September 27, 2001. (DX 3). The Employer has the burden of rebutting the presumption that a claim was timely filed. Employer's counsel did not raise the issue of timeliness at the hearing. Employer, however, asserts in their closing argument that the claim is not timely filed. Employer correctly states "[A] miner's claim for black lung benefits must be filed within three years after medical determination of total disability due to pneumoconiosis is communicated to the miner." Employer asserts that Dr. Cohen's 1997 medical report communicates to the miner a determination that he was totally disabled due to coal workers' pneumoconiosis. A claim filed by Mr. Wells on March 27, 2000 was denied because the evidence failed to establish the element of entitlement that Mr. Wells was totally disabled due to pneumoconiosis.

The United States Court of Appeals for the Fourth Circuit held that the time limitations in 30 U.S.C.A. § 932(f) and 20 C.F.R. § 725.308 apply to duplicate claims as well as initial claims. The Court went on to clarify that, in the context of duplicate claims, a finding by a final adjudicator that the claimant is not totally disabled due to coal workers' pneumoconiosis repudiates any earlier medical determination to the contrary and renders prior medical advice to the contrary ineffective to trigger the running of the statute of limitations. *Westmoreland Coal Co. v. Amick*, Case No. 04-1147 (4th Cir. December 6, 2004)(Unpub.).

On September 6, 2000, the miner's claim was denied because he did not establish total disability due to pneumoconiosis. As such, any determination of total disability due to pneumoconiosis prior to the September 6, 2000 benefit determination is ineffective to trigger the running of the statute of limitations. Thus, the miner's claim for benefits is timely filed.

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[2] 20 C.F.R. § 725.308 (Black Lung Benefits Act as amended, 30 U.S.C.A. §§ 901-945, § 422(f)).

(a) A claim for benefits filed under this part by, or on behalf of, a miner shall be filed within three years after a medical determination of total disability due to pneumoconiosis which has been communicated to the miner or a person responsible for the care of the miner… There is no time limit on the filing of a claim by the survivor of a miner.

(c) There shall be a rebuttable presumption that every claim for benefits is timely field…the time limits in this section are mandatory and may not be waived or tolled except upon a showing of extraordinary circumstances.

C. Responsible Operator[3]

Buffalo Mining Company is the last employer for whom the miner worked a cumulative period of at least one year and is the properly designated responsible coal mine operator in this case, under Subpart G for claims filed on or after Jan. 19, 2001, Part 725 of the Regulations. (DX 9).

D. Dependents

The miner had one dependent for purposes of augmentation of benefits under the Act, his wife Daley Wells. (DX 10).

E. Personal, Employment and Smoking History[4]

The decedent miner was born on May 3, 1937. (DX 3). He passed away on March 7, 2003. (DX 33). He married Daley Wells, the claimant, on October 8, 1957. (DX 10). The miner's last position in the coal mines was that of a beltman. (DX 7). Mr. Wells quit working in the mines in 1984. At that time, he was disabled due to a back injury.

There is evidence of record that the miner's respiratory impairment was due, in part, to his history of cigarette smoking. The evidence is conflicting concerning the miner's smoking history. However, I find, based on the miner's various communications to physicians, he smoked at least a pack of cigarettes per day for fifty years. Mr. Wells had an extensive smoking history. Any discrepancy in the exact number of years the miner smoked in inconsequential for the purposes of rendering this decision.

II. Medical Evidence[5]

The following is a summary of the evidence submitted since the final denial of the prior claim.

A. Chest X-rays[6]

There were four readings of one X-ray, taken on December 11, 2001. (DX 17, 18; EX 8, 9). One is positive, by Dr. Ranavaya, a B-reader.[7] Two are negative, by Drs. Scott and Wheeler, both of whom are dually qualified. Dr. Binns provided a quality only reading.

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[3] Liability for payment of benefits to eligible miners and their survivors rests with the responsible operator. 20 C.F.R. § 725.493(a)(1) defines responsible operator as the claimant's last coal mine employer with whom he had the most recent cumulative employment of not less than one year.

[4] "The BLBA, judicial precedent, and the program regulations do not permit an award based solely upon smoking-induced disability." 65 Fed. Reg. 79948, No. 245 (Dec. 20, 2000).

[5] *Dempsey v. Sewell Coal Co. & Director, OWCP*, ___ B.L.R. ___, BRB Nos. 03-0615 BLA and 03-0615 BLA-A (June 28, 2004). BRB upheld regulatory limitations on the admissibility of medical evidence, under the new 2001 regulations, i.e., 20 C.F.R. Sections 725.414 and 725.456(b)(1).

[6] In the absence of evidence to the contrary, compliance with the requirements of Appendix A shall be presumed. 20 C.F.R. § 718.102(e)(effective Jan. 19, 2001).

Exh. #	Dates: 1. X-ray 2. read	Reading Physician	Qualifications	Film Quality	ILO Classification	Interpretation Or Impression
EX 8	12/11/2001 6/18/2004	Dr. Wheeler	B, BCR	3 light/ poor contrast		No silicosis or CWP but check surgical pathology report from right lung.
EX 9	12/11/2001 6/18/2004	Dr. Scott	B, BCR	3 light		Partial resection right lung and posteria right 6th rib. Minimal linear interstitial fibrosis left apex. Obesity.
DX 17	12/11/2001	Dr. Binns	B, BCR	2 light		Quality-only reading.
DX 18	12/11/2001 12/11/2001	Dr. Ranavaya	B	1	1/2	p/q, all zones.

* A-A-reader; B-B-Reader; BCR – Board Certified Radiologist; BCP – Board-certified pulmonologist; BCI – Board-certified internal medicine; BCI(P) – Board-certified internal medicine with pulmonary medicine sub-specialty. Readers who are Board-certified radiologists and/or B-readers are classified as the most qualified. *See Mullins Coal Co. v. Director, OWCP,* 484 U.S. 135, 145 n. 16, 108 S.Ct. 427, 433 n. 16, 98 L.Ed. 2d 450 (1987) and, *Old Ben Coal Co. v. Battram,* 7 F.3d 1273, 1276 n. 2 (7th Cir. 1993). B-readers need not be radiologists.

**The existence of pneumoconiosis may be established by chest X-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. A chest X-ray classified as category "0," including subcategories "0/-, 0/0, 0/1," does not constitute evidence of pneumoconiosis. 20 C.F.R. § 718.102(b). In some instances, it is proper for the judge to infer a negative interpretation where the reading does not mention the presence of pneumoconiosis. *Yeager v. Bethlehem Mines Corp*., 6 B.L.R. 1-307 (1983) (Under Part 727 of the Regulations) and *Billings v. Harlan #4 Coal Co.*, BRB No. 94-3721 (June 19, 1997)(*en banc)(Unpublished)*. If no categories are chosen, in box 2B(c) of the X-ray form, then the x-ray report is not classified according to the standards adopted by the regulations and cannot, therefore, support a finding of pneumoconiosis.

B. Pulmonary Function Studies

Pulmonary Function Studies ("PFS") are tests performed to measure the degree of impairment of pulmonary function. They range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1) and maximum voluntary ventilation (MVV).

[7] *LaBelle Processing Co. v. Swarrow,* 72 F.3d 308 (3rd Cir. 1995) at 310, n. 3. "A "B-reader" is a physician, often a radiologist, who has demonstrated proficiency in reading X-rays for pneumoconiosis by passing annually an examination established by the National Institute of Safety and Health and administered by the U.S. Department of Health and Human Services. *See* 20 C.F.R. § 718.202(a)(1)(ii)(E); 42 C.F.R. § 37.51. Courts generally give greater weight to X-ray readings performed by "B-readers." *See Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16, 108 S.Ct. 427, 433 n. 16, 98 L.Ed. 2d 450 (1987); *Old Ben Coal Co. v. Battram*, 7 f.3d 1273, 1276 n. 2 (7th Cir. 1993)."

Physician Date Exh.#	Age Height	FEV₁	MVV	FVC	Tracings	Comprehension Cooperation	Qualify * Conform**
Dr. Ranavaya 12/11/2001 DX 16	64 64”	2.34		3.16	Yes	Good Fair	No Yes
Dr. Ranavaya 12/11/2001 DX 16 Post-Bron	64 64”	2.33		3.24	Yes	Good Fair	No Yes

*A “**qualifying**” pulmonary study or arterial blood gas study yields values which are equal to or less than the applicable table values set forth in Appendices B and C of Part 718.

** A study “**conforms**” if it complies with applicable standards (found in 20 C.F.R. § 718.103(b) and (c)). (*See Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 (7th Cir. 1993)). A judge may infer in the absence of evidence to the contrary, that the results reported represent the best of three trials. *Braden v. Director, OWCP,* 6 B.L.R. 1-1083 (1984). A study which is not accompanied by three tracings may be discredited. *Estes v. Director, OWCP*, 7 B.L.R. 1-414 (1984).

For a miner of the claimant’s height of 64 inches, § 718.204(b)(2)(i) requires an FEV_1 equal to or less than 1.53 for a male 64 years of age. If such an FEV_1 is shown, there must be in addition, an FVC equal to or less than 1.97 or an MVV equal to or less than 61; or a ratio equal to or less than 55% when the results of the FEV_1 tests are divided by the results of the FVC test.

C. Arterial Blood Gas Studies[8]

Blood gas studies are performed to detect an impairment in the process of alveolar gas exchange. This defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. A lower level of oxygen (O2) compared to carbon dioxide (CO2) in the blood, expressed in percentages, indicates a deficiency in the transfer of gases through the alveoli which will leave the miner disabled.

Date Ex. #	Physician	PCO2	PO2	Qualify	Physician Impression
12/11/2001 DX 15	Dr. Ranavaya	22 29.2*	101 74.6*	No No	Mr. Wells was hyperventilating while undergoing the resting arterial blood gas study.

*Results, if any, after exercise. Exercise studies are not required if medically contraindicated. 20 C.F.R. § 718.105(b).

[8] 20 C.F.R. § 718.105 sets the quality standards for blood gas studies.
20 C.F.R. §718.204(b)(2) permits the use of such studies to establish “total disability.” It provides: In the absence of contrary probative evidence which meets the standards of either paragraphs (b)(2)(i), (ii), (iii), or (iv) of this section shall establish a miner’s total disability:…
(2)(ii) Arterial blood gas tests show the values listed in Appendix C to this part…

D. Physicians' Reports[9]

A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative X-ray, finds that the miner suffers or suffered from pneumoconiosis. 20 C.F.R. § 718.202(A)(4). Where total disability cannot be established, under 20 C.F.R. § 718.204(b)(2)(i) through (iii), or where pulmonary function tests and/or blood gas studies are medically contraindicated, total disability may be nevertheless found, if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable and gainful work. § 718.204(b).

Dr. Perper is Board-certified in anatomic, surgical and forensic pathology. His report, based upon his review of the medical records of the miner and nine histological slides of resected lung lobe, dated May 20, 2004,[10] notes 10 years of coal mine employment. Dr. Perper reiterated the work histories and smoking histories noted in the miner's medical records. (CX 1).

Dr. Perper listed his microscopic diagnoses of the resected right upper and middle pulmonary lobes as:

1. Squamous cell carcinoma of the lung, well differentiated;
2. Simple coal workers' pneumoconiosis, slight to moderate severity;
3. Centrilobular emphysema, moderate to severe;
4. Sclerosis of intra-pulmonary blood vessels consistent with pulmonary hypertension and cor pulmonale;
5. Foci of acute bronchopneumonia; and
6. Fibro-anthracosis of extra-pulmonary lymph nodes, marked.

(CX 1).

Based on his review of the medical records and histological slides, Dr. Perper concluded that Mr. Wells had significant coal workers' pneumoconiosis during his lifetime. (CX 1).

Dr. Perper noted that smoking causes centrilobular emphysema. He described the miner's smoking history as "significant." Dr. Perper further stated "as abundantly substantiated in reliable scientific literature in last decades, centrilobular emphysema is also a direct result of exposure to mixed coal mine dust containing silica and coal workers' pneumoconiosis." (CX 1).

Dr. Perper further concluded that the miner's coal workers' pneumoconiosis was a substantial contributory cause of death. Dr. Perper stated that the miner's lung cancer was related to two etiological factors: (1) long history of heavy smoking and (2) significant coal workers' pneumoconiosis and occupational exposure as a miner to mixed coal dust containing silica. (CX 1). Dr. Perper opined "coal workers' pneumoconiosis and the causally associated centrilobular emphysema, and pulmonary cancer, were in tandem effective combined causes of

[9] *Dempsey v. Sewell Coal Co. & Director, OWCP*, ___ B.L.R. ___, BRB Nos. 03-0615 BLA and 03-0615 BLA-A (June 28, 2004). Under (new) 2001 regulations, expert opinions must be based on admissible evidence.

[10] The date on the report is March 2004. This was a typographical error. At Dr. Perper's deposition, the discrepancy was clarified.

death, that resulted in pulmonary insufficiency and hypoxemia, and terminal bronchopneumonia." (CX 1).

Dr. Perper was deposed on August 12, 2004. (CX 3). Prior to being deposed, Dr. Perper reviewed his own report and Dr. Naeye's reports, dated November 16, 2003 and June 9, 2004. Dr. Perper testified that Dr. Naeye's reports contain a contradiction in terms. Dr. Perper states that, in his 2003 report, Dr. Naeye says there are no crystals and does not mention the presence of any crystals. He notes that, in his 2004 report, Dr. Naeye, in response to Dr. Perper's crystal findings, states that he too found an occasional small anthracotic deposit and a few presumed silica crystals. Dr. Perper points out the contradiction that Dr. Naeye's first report mentions no crystals and the second report mentions crystals. (CX 3, p. 7).

Dr. Perper testified that he saw birefringent silica crystals on the slides he examined. In attempting to explain why Dr. Naeye did not make the same finding, Dr. Perper stated:

> I believe that the polarizing microscope of Dr. Naeye is not strong enough. And that's the reason why he doesn't see the small fine birefringent silica crystals, which are small and require a more powerful and better polarizing microscope. That's my only explanation. But obviously, he either missed or disregarded the first time when he looked at the slides and he missed those crystals, which he found them on the second examination.

(CX 3, p. 8). Dr. Perper disagrees with Dr. Naeye's finding of a very small amount of black pigment in the miner's lungs. Additionally, Dr. Perper cited various publications to rebut Dr. Naeye's argument that coal workers' pneumoconiosis does not cause centrilobular emphysema. (CX 3, pp. 10-11).

During his deposition, Dr. Perper reiterated his stance that coal mine dust inhalation caused, at least in part, Mr. Wells' lung cancer. He also relates Mr. Wells' smoking history as a cause of his lung cancer. Dr. Perper stated "the cancer developed in the area in which the process of coal workers' pneumoconiosis was more severe." (CX 3, pp. 12-13). Dr. Perper referenced a study by the International Association for Research on Cancer (IARC) on page 23 of his report. On cross-examination, Dr. Perper testified "but I think that they did not find, at the time when they [IARC] issued their report several years ago, that coal dust containing silica is carcinogenic." (CX 3, p. 23).

Dr. Perper provided the following explanation of his diagnosis of Mr. Wells:

> The exposure to coal dust created a triple pathology which is the coal workers' pneumoconiosis, the associated complicating emphysema and the complicated cancer of the lung. And the smoking created the double pathology, the emphysema and the cancer of the lung.

(CX 3, p. 30).

Dr. Perper reiterated his conclusion that pneumoconiosis hastened the miner's death. (CX 3, p. 14). Dr. Perper testified on cross-examination that Mr. Wells had two types of pneumoconiosis. He stated that Mr. Wells had clinical and legal pneumoconiosis. Dr. Perper

described the legal pneumoconiosis as "the complication of coal workers' pneumoconiosis, the centrilobular emphysema and the cancer." Dr. Perper stated that a combination of the two types of pneumoconiosis was "certainly disabling." He further stated that the "medical coal workers' pneumoconiosis, the nodules and macules and the interstitial fibrosis," would have been disabling by themselves. He explained that the extent and severity would have been disabling to Mr. Wells. (CX 3, p. 17).

Dr. Perper testified that he did not form an opinion as to the miner's degree of impairment during his lifetime. Dr. Perper explained "I was asked to evaluate whether coal workers' pneumoconiosis was present and whether it contributed to the death." Dr. Perper goes on to answer "I believe that most likely he had pulmonary impairment" before death. (CX 3, p. 40). Dr. Perper also concluded that Mr. Wells had variable hypoxemia. (CX 3, p. 41).

Dr. Perper did not diagnosis silicosis in Mr. Wells' case. He explained: "In this particular case, there was several silicotic type of micronodules, but the process was the process of coal workers' pneumoconiosis with presence of occasional silicotic micronodules. But not silicosis, pure silicosis." (CX 3, p. 20). The following is Dr. Perper's testimony regarding silicates and carcinogenics:

> Q: Why do you offer the opinion that silicates are carcinogenic?
> A: There was no study about silicates, carcinogenic. I misspoke. I wanted to say that silicates are damaging in terms of the probability of causing emphysema and lung destruction. There's no literature that I'm aware that silicates cause cancer.
> Q: You referenced to a whole series of articles that you used to link cancer to coal dust exposure?
> A: Yes.
> Q: Do you believe those articles support the association between exposure to coal mine dust and lung cancer?
> A: I think that they do and I just explained to you why I do believe that the articles do that. Because silica has been recognized very clearly as being carcinogenic for humans. It can cause and it does cause cancer in humans. … And it's equally susceptive to the damaging effect of the silica which is carcinogenic.

(CX 3, pp. 28-29).

Dr. Naeye is Board-certified in anatomic and clinical pathology. His consultation report, based upon his review of the medical records of the claimant, dated November 16, 2003, notes 9 years of coal mine employment and a 40-60 pack-year smoking history. Dr. Naeye reviewed hospital records, physician reports and 14 glass slides with lung tissues removed at the autopsy. (EX 3).

When examining the autopsy slides, Dr. Naeye found a very small amount of black pigment. The pigment deposits were less than 1 mm in diameter. Dr. Naeye found two dominating findings: (1) massive acute lobular pneumonia and (2) the presence at many sites of nests and larger deposits of poorly differentiated squamous cell carcinoma. Dr. Naeye noted very

severe chronic bronchitis. Dr. Naeye opined that the chronic bronchitis was caused by his life-long cigarette smoking. (EX 3).

Based on his review of the autopsy slides, Dr. Naeye concluded that the few small black deposits in the lungs were not sufficient for even a diagnosis of very mild, simple coal workers' pneumoconiosis. Dr. Naeye did not find any coal dust related disability. As such, Dr. Naeye stated that pneumoconiosis could not have caused the miner's death or any lifetime disability. (EX 3).

Dr. Naeye pointed out that experienced pulmonologists concluded that pneumoconiosis was present and contributed to the miner's disability. He disagrees with such findings and notes the difficulty in distinguishing between the effects of coal mine dust and cigarette smoking on the lungs when no lung tissue is available for review. (EX 3).

On June 9, 2004, Dr. Naeye prepared a supplemental report. (EX 5). Dr. Naeye reviewed his previous report and Dr. Perper's consultation report. Dr. Perper concluded that the miner had simple coal workers' pneumoconiosis. Dr. Perper found "birefringent silica crystals." Dr. Naeye points out that Dr. Perper did not mention the size of the crystals. Dr. Naeye clarified "I too found an occasional small anthracotic deposit and a few presumed silica crystals associated with black pigment in areas where there were large masses of cancer cells in the lungs of James Wells." He explained that he attributed the fibrosis to the therapy which had been directed against the cancer because the birefringent crystals were far too large to have been fibrogenic. (EX 5). Dr. Naeye opined that Mr. Wells could have returned to coal mine work as far as his lungs were concerned. (EX 5).

Dr. Naeye disagrees with Dr. Perper's conclusion that coal dust exposure causes lung cancer. Dr. Naeye further asserted that Dr. Perper's conclusion that the miner's coal dust exposure had a major role in his development of centrilobular emphysema and lung cancer are based on publications from foreign nations. Dr. Naeye noted that the composition of coal mine dust differs from one geographic location to another. (EX 5).

Dr. Zaldivar is a B-reader and is Board-certified in pulmonary disease and internal medicine. His consultation report, based upon his review of the medical records of the miner, is dated June 23, 2003. Dr. Zaldivar examined the miner in 1985. At that examination, Dr. Zaldivar diagnosed simple pneumoconiosis. Dr. Zaldivar examined Mr. Wells for a second time in 1990. He again diagnosed simple pneumoconiosis. In addition to his own examination reports, Dr. Zaldivar also reviewed reports by Dr. Ranavaya, records from Logan General Hospital and Claimant's death certificate. Dr. Zaldivar does not explicitly state the miner's years of coal mine employment in his July 23, 2003 report. He notes Dr. Ranavaya's finding of 11 ¾ years of coal mine employment. As he notes this without objection, it is assumed that Dr. Zaldivar found Mr. Wells to have worked at least 11 years in the coal mines. Dr. Zaldivar described Mr. Wells as a "lifelong intensive smoker of as much as 2-3 packs of cigarettes per day." (EX 1).

Based on his examinations and review of the evidence, Dr. Zaldivar diagnosed coal workers' pneumoconiosis. (EX 1).

Dr. Zaldivar concluded that the miner's minimal respiratory impairment was of no clinical significance. He related such impairment to the miner's "very intensive" smoking history. Dr. Zaldivar noted that the miner's ventilatory studies hovered between mild airway obstruction to normal. He noted that the miner's blood gases were normal, even after resection of the right upper and right middle lobe due to cancer. Dr. Zaldivar opined that, prior to his death, Mr. Wells had the pulmonary capacity to perform his usual coal mine work. Dr. Zaldivar further concluded that coal workers' pneumoconiosis did not cause the miner's death. (EX 1). Dr. Zaldivar further stated: "There is a gap in the records which you sent me where metastasis of the lung cancer was found. I am sure, based on my experience treating individuals with lung cancer which has spread, that at some point Mr. Wells was incapacitated and incapable of performing any work at all due to the spread of the cancer." Dr. Zaldivar clarified that "[L]ung cancer has never been found to be the result of coal worker's pneumoconiosis." (EX 1).

Dr. Zaldivar was deposed on June 7, 2004. (EX 6). Dr. Zaldivar concluded that the miner had radiographic evidence of coal workers' pneumoconiosis. He stated that the miner's pneumoconiosis contributed to a minimal airway obstruction. Dr. Zaldivar clarified that the miner's heavy smoking habit also contributed to the minimal airway obstruction. He noted that the minimal obstruction was insignificant. (EX 6, p.6).

Dr. Zaldivar testified regarding the miner's complaint of shortness of breath, documented in numerous reports. Dr. Zaldivar stated that shortness of breath is subjective and does not necessarily mean that there is any lung pathology or heart pathology. He noted that two common problems associated with a complaint of shortness of breath are anxiety and physical deconditioning. Dr. Zaldivar also listed coronary artery disease and lung disease as problems associated with shortness of breath. In discussing an American Medical Association publication, Dr. Zaldivar stated "if a breathing test is entirely normal, the complaints of shortness of breath are due to something other than the lungs." (EX 6, p. 10). Dr. Zaldivar discussed an arterial blood gas study he performed on Mr. Wells in 1990. He noted that the PO2 was 88 at rest and 76 with exercise. Dr. Zaldivar explained that the PO2 would have to get down into the low sixties to produce any sensation of shortness of breath. (EX 6, p. 12).

Dr. Zaldivar concluded, at the time of his 1990 examination, that Mr. Wells never had a totally disabling pulmonary impairment. He determined that, from a pulmonary standpoint, Mr. Wells could have performed his previous coal mine work. Dr. Zaldivar testified regarding his 2003 report. At the time of that report, Dr. Zaldivar testified that Mr. Wells had a disability due to his cancer, but he did not have any impairment. (EX 6, p. 13). Dr. Zaldivar noted that despite the fact that around 30 percent of the miner's lung was removed, the breathing capacity remained normal. (EX 6, p. 14).

Dr. Zaldivar testified that the miner's pneumoconiosis was not causing any significant problem before or after the cancer was diagnosed. (EX 6, p. 17). In 2001, a doctor at Logan General Hospital diagnosed cancer and severe chronic obstructive pulmonary disease. Dr. Zaldivar disagrees with the severe chronic obstructive pulmonary disease diagnosis. Dr. Zaldivar could not determine what information was relied upon by the Logan General Hospital in making such finding. (EX 6, p. 17). Additionally, Dr. Zaldivar did not agree with the diagnosis of chronic obstructive pulmonary disease on the miner's death certificate. Dr. Zaldivar

noted that a death certificate is completed with the information that the physician has at hand, which may or may not be factual information. (EX 6, pp. 22-24).

Dr. Zaldivar did not have any medical information between 2001 and the miner's death in 2003. Thus, Dr. Zaldivar did not have evidence that prior to his death Mr. Wells developed a totally disabling pulmonary impairment. Dr. Zaldivar speculated that if Mr. Wells developed a totally disabling pulmonary impairment, then it was a result of metastatic cancer of the lung. (EX 6, p. 21). Dr. Zaldivar testified that "there is absolutely no evidence that pneumoconiosis played any role whatsoever in his [Mr. Wells'] death." (EX 6, p. 24).

Dr. Zaldivar testified regarding the findings in Dr. Perper's report. Dr. Perper found evidence of simple pneumoconiosis, lung cancer, centrilobular emphysema and pneumonia. Dr. Zaldivar stated that these conclusions are documented in the miner's medical records and not surprising. Dr. Zaldivar agreed with Dr. Perper's pneumoconiosis finding. Dr. Zaldivar disagreed with Dr. Perper's conclusion that coal dust exposure contributed to the miner's centrilobular emphysema. Dr. Zaldivar opined that smoking caused the miner's centrilobular emphysema. Additionally, Dr. Zaldivar concluded that the miner's centrilobular emphysema did not cause or contribute to his death. (EX 6, pp. 25-27, 33). Dr. Zaldivar testified that Dr. Perper's finding that the miner's coal workers' pneumoconiosis and silicosis caused his lung cancer is unfounded. Dr. Zaldivar stated that there is no evidence that Mr. Wells had silicosis. (EX 6, p. 35). On cross-examination, Dr. Zaldivar explained that silicosis has been linked to cancer. (EX 6, p. 61). Dr. Zaldivar stated that squamous carcinoma is the most common lung cancer in smokers. (EX 6, p. 36).

On cross-examination, Dr. Zaldivar testified that ten years of coal dust exposure is not enough to cause a typical individual to develop disabling coal workers' pneumoconiosis. (EX 6, p. 47). Dr. Zaldivar diagnosed radiographic pneumoconiosis at Mr. Wells' 1985 and 1990 examinations. Both X-rays were interpreted as having a 2/2 profusion. (EX 6, p. 54).

Dr. Castle is a B-reader and is Board-certified in internal medicine with a subspecialty in pulmonary disease. His consultation report, based upon his review of the medical records of the miner, dated July 23, 2003, notes 14 years of coal mine employment and a 50 pack-year smoking history. (EX 2).

Based on arterial blood gases, pulmonary function studies, chest X-rays, and physician opinions, Dr. Castle found radiographic evidence of simple coal workers' pneumoconiosis. Dr. Castle noted that Mr. Wells worked in the mines for a sufficient enough time to have developed coal workers' pneumoconiosis if he were a susceptible host. (EX 2). Dr. Castle described the miner's smoking history as very lengthy and extensive. He noted that such smoking history is significant enough to cause chronic obstructive pulmonary disease. (EX 2).

Dr. Castle noted the miner's right lobectomy for squamous cell carcinoma of the lung. Dr. Castle clarified that this tumor was directly related to tobacco smoking and is not related to coal mine dust inhalation. (EX 2).

Dr. Castle concluded that the physiologic studies showed a very minimal degree of airway obstruction, which would be deemed clinically insignificant. He opined that Mr. Wells

was not permanently and totally disabled as a result of any pulmonary process arising from his coal mine employment. He further noted that it is unlikely that the miner's death was in any way related to his simple coal workers' pneumoconiosis. (EX 2).

Dr. Castle was deposed by Employer's counsel on December 16, 2003. (EX 4). In preparation for the deposition, Dr. Castle reviewed medical records from Logan Regional Medical Center, Dr. Naeye's November 16, 2003 report, two X-ray reports, Dr. Racadag's autopsy report and his own July 23, 2003 report based on his review of the medical records. (EX 4, pp. 9-10).

Dr. Castle described the miner's coal mine work as heavy manual labor. He determined the miner's smoking history to be in excess of a 50 pack-year history. (EX 4, p. 11).

In determining whether Mr. Wells had the pulmonary ability to return to his previous coal mine employment, Dr. Castle reviewed the miner's physiologic studies. He noted that some of the studies showed a very minimal degree of airway obstruction, which would be clinically insignificant. Dr. Castle did not find a disabling abnormality from any cause. (EX 4, p.12). Dr. Castle discussed an arterial blood gas study by Dr. Ranavaya which showed a reduction in PO2 from 101 down to 74.6. Dr. Castle explained that this study was taken after two-thirds of the miner's right lung was removed. He stated that such removal takes away a large amount of functional lung tissue and, thus, could result in a fall in the PO2 with exercise. (EX 4, p.15).

In Dr. Castle's July 23, 2003 report, he concluded that the miner had radiographic evidence of simple coal workers' pneumoconiosis. After reviewing the further medical evidence noted above, Dr. Castle changed the conclusion he reached in July 2003. Dr. Castle testified that Mr. Wells "did not have pathologic evidence of coal workers' pneumoconiosis." He further explains "[I]f he did not have pathologic evidence, then one cannot render a diagnosis of coal workers' pneumoconiosis." Dr. Racadag found simple coal workers' pneumoconiosis. Dr. Naeye did not find evidence sufficient to justify a diagnosis of simple coal workers' pneumoconiosis. Dr. Castle explained that he found Dr. Naeye's discussion more persuasive that Dr. Racadag's findings. (EX 4, p.16).

Dr. Castle further testified that coal mine dust exposure did not play any role in the miner's death. Dr. Castle stated: "He died as a result of complications from his therapy, of metastatic cancer, lung cancer. He died as a result of an overwhelming massive pneumonia which is an infectious process occurring acutely as a result of the immunocompromise due to cancer and chemotherapy. The cancer was a bronchogenic carcinoma due to smoking." (EX 4, p. 21). Dr. Castle noted that despite the fact that Mr. Wells had cancer due to smoking, he did not have respiratory impairment due to smoking. Dr. Castle clarified that there is no evidence that coal mine dust exposure causes cancer. (EX 4, p. 22).

Dr. Castle testified that, prior to his death, Mr. Wells had the respiratory capacity to perform his last usual coal mine employment. Dr. Castle further noted that, prior to his death, Mr. Wells "was disabled as a whole man because of lung cancer." (EX 4, p. 23).

Dr. Castle submitted a second consultation report, dated June 16, 2004. (EX 7). Dr. Castle reviewed reports by Drs. Perper and Zaldivar. Dr. Castle reiterated his opinion that

Mr. Wells had radiographic and pathologic evidence of simple coal workers' pneumoconiosis. He also restated that Mr. Wells had no significant respiratory impairment. Dr. Castle noted that "at most" Mr. Wells had a very mild degree of airway obstruction associated with intermittent and variable oxygenation. He stated: "It is my opinion that the variability in his degree of oxygenation was related to his very long and extensive tobacco smoking habit with ventilation/perfusion mismatching." (EX 7).

Dr. Castle determined the miner's cause of death to be complications from metastatic squamous cell carcinoma. Dr. Castle listed smoking as the cause of the squamous cell carcinoma. Dr. Castle disagreed with Dr. Perper's conclusion that the miner's coal dust exposure caused his lung cancer. (EX 7).

Dr. Ranavaya, who is a B-reader and Board-certified in occupational medicine, performed the Department of Labor examination of Mr. Wells on December 11, 2001. (DX 14). His report notes 11 ¾ years of coal mine employment and a more than 50-year smoking history. Dr. Ranavaya notes that Mr. Wells smoked 1-2 packs of cigarettes per day. Dr. Ranavaya notes that Mr. Wells stopped working in 1984 when he was disabled due to back problems. Dr. Ranavaya lists the miner's medical history as including frequent colds, attacks of wheezing, chronic bronchitis, arthritis, heart disease, allergies, lung cancer, and high blood pressure. He notes that, in 2001, the miner had a right lung biopsy and right mid and upper lung lobe surgery. Under present complaints and symptoms, Dr. Ranavaya listed Mr. Wells as having daily sputum, daily wheezing, dyspnea, cough, hemoptysis, chest pain, orthopnea, ankle edema and paroxysmal nocturnal dyspnea. He notes that Mr. Wells complained of shortness of breath upon minimal exertion. (DX 14).

Based on an arterial blood gas study, pulmonary function study, and a positive chest X-ray, Dr. Ranavaya diagnosed Mr. Wells with pneumoconiosis, right lung cancer, coronary artery disease and hypertension. He noted that the miner's pneumoconiosis was caused by occupational exposure to dust in coal mining. (DX 14).

Dr. Ranavaya opined that Mr. Wells had a minimal pulmonary impairment which in and of itself would not have prevented him from performing his last coal mine job. He stated that the miner's pneumoconiosis contributed to his impairment "to a minimal extent." (DX 14).

III. Death Certificate

The miner's death certificate, signed by Dr. Steve Nathanson, lists the date of death as March 7, 2003. The immediate cause of death was determined to be cardio-respiratory arrest due to pneumonia. Under other significant conditions contributing to death but not resulting in the underlying cause, Dr. Nathanson lists metastatic cancer lung, COPD, and pneumoconiosis. (DX 33).

IV. Hospital Records

Mr. Wells was admitted to Logan General Hospital on June 14, 2001 and discharged on June 25, 2001. (DX 12). The hospital record contains the following summary of Mr. Wells' condition:

> This is a 64 year old, white, male who was diagnosed to have right upper lobe squamous cell carcinoma by mediastinoscopy and definitive surgical treatment was advised. The patient was admitted on 6-14-01 after right thoracotomy, right upper and middle lobe lobectomy under general endotracheal and isolated pulmonary ventilation. The patient had history of laryngeal cancer in which he underwent radiation treatment in the past. The patient has pneumoconiosis, severe COPD, hypertension and chronic low back pain.

(DX 12). The hospital record also lists the miner as a current smoker as of June 2001. The record states that Mr. Wells previously smoked 2-3 packs of cigarettes per day and at the time of hospital admission was smoking one pack per day. (DX 12).

Mr. Wells was treated in the hospital by Drs. Pathom and Rao. The record lists the final diagnosis as squamous cell carcinoma of the right upper lobe, severe chronic obstructive pulmonary disease, pneumoconiosis, and history of low back pain. (DX 12).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

A. Entitlement to Benefits

This claim must be adjudicated under the regulations at 20 C.F.R. Part 718 because it was filed after March 31, 1980. Under this Part, the claimant must establish, by a preponderance of the evidence, that: (1) he has pneumoconiosis; (2) his pneumoconiosis arose out of coal mine employment; and, (3) he is totally disabled due to pneumoconiosis. Failure to establish any one of these elements precludes entitlement to benefits. 20 C.F.R. §§ 718.202-718.205; *Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-112 (1989); *Trent v. Director, OWCP*, 11 B.L.R. 1-26 (1987); and, *Perry v. Director, OWCP*, 9 B.L.R. 1-1 (1986). *See Lane v. Union Carbide Corp.*, 105 F.3d 166, 170 (4th Cir. 1997). The claimant bears the burden of proving each element of the claim by a preponderance of the evidence, except insofar as a presumption may apply. *See Director, OWCP v. Mangifest*, 826 F.2d 1318, 1320 (3rd Cr. 1987). Failure to establish any of these elements precludes entitlement. *Perry v. Director, OWCP,* 9 B.L.R. 1-1 (1986).

Since this is the miner's fourth claim for benefits, and it was filed on or after January 19, 2001, it must be adjudicated under the new regulations.[11] Although the new regulations dispense

[11] Section 725.309(d)(For duplicate claims filed on or after Jan. 19, 2001)(65 Fed. Reg. 80057 & 80067):

(d) If a claimant files a claim under this part more than one year after the effective date of a final order denying a claim previously filed by the claimant under this part (see § 725.502(a)(2)), the later claim shall be considered a subsequent claim for benefits. A subsequent claim shall be processed and adjudicated in accordance with the provisions of subpart E and F of this part, except that the claim shall be denied unless the claimant demonstrates that one of the applicable conditions of entitlement (see Sections 725.202(d)(miner), 725.212(spouse), 725.218(child), and 725.222(parent, brother or sister)) has changed since the date upon which the order denying the prior claim became final. The applicability of this paragraph may be waived by the operator or fund, as appropriate. The following additional rules shall apply to the adjudication of a subsequent claim:

(1) any evidence submitted in connection with any prior claim shall be made a part of the record in the subsequent claim, provided that it was not excluded in the adjudication of the prior claim.

(2) For purposes of this section, the applicable conditions of entitlement shall be limited to those conditions upon which the prior denial was based. For example, if the claim was denied solely on the basis that the individual

with the "material change in conditions" language of the older regulations, the criteria remain similar to the "one-element" standard set forth by the Sixth Circuit in *Sharondale Corp. v. Ross*, 42 F.3d 993 (6th Cir. 1994), which was adopted by the United States Court of Appeals for the Fourth Circuit, in *Lisa Lee Mines v. Director, OWCP [Rutter]*, 86 F.3d 1358 (4th Cir. 1996)(*en banc*) *rev'g* 57 F.3d 402 (4th Cir. 1995), *cert. den.* 117 S.Ct. 763 (1997). In *Dempsey v. Sewell Coal Co. & Director, OWCP*, ___ B.L.R. ___, BRB Nos. 03-0615 BLA and 03-0615 BLA-A (June 28, 2004), the Board held that where a miner files a claim for benefits more than one year after the final denial of a previous claim, the subsequent claim must also be denied unless the administrative law judge finds that "one of the applicable conditions of entitlement…has changed since the date upon which the order denying the prior claim became final." 20 C.F.R. Section 725.309(d); *White v. New White Coal Co., Inc.*, 23 B.L.R. 1-1, 1-3 (2004). According to the Board, the "applicable conditions of entitlement" are "those conditions upon which the prior denial was based." 20 C.F.R. Section 725.309(d)(2).

To assess whether a material change in conditions is established, the Administrative Law Judge ("Administrative Law Judge") must consider all of the new evidence, favorable and unfavorable, and determine whether the claimant has proven, at least one of the elements of entitlement previously adjudicated against him in the prior denial of September 6, 2000, i.e., disability due to the disease. *Lisa Lee Mines v. Director, OWCP [Rutter]*, 86 F.3d 1358 (4th Cir. 1996)(*en banc*) *rev'g* 57 F.3d 402 (4th Cir. 1995), *cert. den.* 117 S.Ct. 763 (1997). *See Hobbs v. Clinchfield Coal Co.*, 917 F.2d 790, 792 (4th Cir. 1990). If the miner establishes the existence of that element, he has demonstrated, as a matter of law, a material change. Unlike the Sixth Circuit in *Sharondale,* the Fourth Circuit does not require consideration of the evidence in the prior claim to determine whether it "differ[s] qualitatively" from the new evidence. *Lisa Lee Mines*, 86 F.3d at 1363 n. 11. The Administrative Law Judge must then consider whether all of the record evidence, including that submitted with the previous claim, supports a finding of entitlement to benefits.

The miner's third application for benefits was denied because the evidence failed to show that the miner was totally disabled by pneumoconiosis. Under the *Sharondale* standard, the claimant must show the existence of this element by way of newly submitted medical evidence in order to show that a material change in condition has occurred. If he can show that a material change has occurred, then the entire record must be considered in determining whether he is

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was not a miner, the subsequent claim must be denied unless the individual worked as a miner following the prior denial. Similarly, if the claim was denied because the miner did not meet one or more of the eligibility criteria contained in part 718 of this subchapter, the subsequent claim must be denied unless the miner meets at least one of the criteria that he or she did not meet previously.

(3) If the applicable condition(s) of entitlement relate to the miner's physical condition, the subsequent claim may be approved only if new evidence submitted in connection with the subsequent claim establishes at least one applicable condition of entitlement. A subsequent claim filed by a surviving spouse, child, parent, brother, or sister shall be denied unless the applicable conditions of entitlement in such claim include at least one condition unrelated to the miner's physical condition at the time of his death.

(4) If the claimant demonstrates a change in one of the applicable conditions of entitlement, no findings made in connection with the prior claim, except those based on a party's failure to contest an issue (see § 725.463), shall be binding on any party in the adjudication of the subsequent claim. However, any stipulation made by any party in connection with the prior claim shall be binding on that party in the adjudication of the subsequent claim.

(5) In any case in which a subsequent claim is awarded, no benefits may be paid for any period prior to the date upon which the order denying the prior claim became final.

entitled to benefits. As discussed below, I find that the Claimant did not prove that the miner was totally disabled due to coal workers' pneumoconiosis. Thus, Claimant did not prove a material change in condition.

B. Existence of Pneumoconiosis

Pneumoconiosis is defined as a "chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment."[12] 30 U.S.C. § 902(b) and 20 C.F.R. § 718.201. The definition is not confined to "coal workers' pneumoconiosis," but also includes other diseases arising out of coal mine employment, such as anthracosilisosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, progressive massive fibrosis, silicosis, or silicotuberculosis. 20 C.F.R. § 718.201.[13]

The term "arising out of coal mine employment" is defined as including "any chronic pulmonary disease resulting in respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment."[14] Thus, "pneumoconiosis", as defined by the Act, has a much broader legal meaning than does the medical definition.

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[12] Pneumoconiosis is a progressive and irreversible disease; once present, it does not go away. *Mullins Coal Co. v. Director, OWCP,* 484 U.S. 135, 151 (1987); *Lisa Lee Mines v. Director*, 86 F.3d 1358 (4th Cir. 1996)(*en banc*) at 1362; *LaBelle Processing Co. v. Swarrow*, 72 F.3d 308 (3rd Cir. 1995) at 314-315. In *Henley v. Cowan and Co*., 21 B.L.R. 1-148 (May 11, 1999), the Board holds that aggravation of a pulmonary condition by dust exposure in coal mine employment must be "significant and permanent" in order to qualify as CWP, under the Act.

[13] Regulatory amendments, effective January 19, 2001, state:

(a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis.

(1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconiosis, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.

(2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

(Emphasis added).

[14] The definition of pneumoconiosis, in 20 C.F.R. section 718.201, does not contain a requirement that "coal dust specific diseases …attain the status of an "impairment" to be so classified. The definition is satisfied "whenever one of these diseases is present in the miner at a detectable level; whether or not the particular disease exists to such an extent as to become compensable is a separate question." Moreover, the legal definition of pneumoconiosis "encompasses a wide variety of conditions; among those are diseases whose etiology is not the inhalation of coal dust, but whose respiratory and pulmonary symptomatology have nevertheless been made worse by coal dust exposure. *See, e.g., Warth*, 60 F.3d at 175." *Clinchfield Coal v. Fuller*, 180 F.3d 622 (4th Cir. June 25, 1999) at 625.

"…[T]his broad definition 'effectively allows for the compensation of miners suffering from a variety of respiratory problems that may bear a relationship to their employment in the coal mines.'" *Robinson v. Pickands Mather & Co./Leslie Coal Co. & Director, OWCP*, 14 B.L.R. 2-68 (4th Cir. 1990) at 2-78, 914 F.2d 35 (4th Cir. 1990) *citing, Rose v. Clinchfield Coal Co.*, 614 F.2d 936, 938 (4th Cir. 1980).

Thus, asthma, asthmatic bronchitis, or emphysema may fall under the regulatory definition of pneumoconiosis if they are related to coal dust exposure. *Robinson v. Director, OWCP*, 3 B.L.R. 1-798.7 (1981); *Tokarcik v. Consolidation Coal Co.*, 6 B.L.R. 1-666 (1983). Likewise, chronic obstructive pulmonary disease may be encompassed within the legal definition of pneumoconiosis. *Warth v. Southern Ohio Coal Co.*, 60 F.3d 173 (4th Cir. 1995) and *see* § 718.201(a)(2).

The claimant has the burden of proving the existence of pneumoconiosis. The Regulations provide the means of establishing the existence of pneumoconiosis by: (1) a chest X-ray meeting the criteria set forth in 20 C.F.R. § 718.202(a)(1); (2) a biopsy or autopsy conducted and reported in compliance with 20 C.F.R. § 718.106; (3) application of the irrebuttable presumption for "complicated pneumoconiosis" found in 20 C.F.R. § 718.304; or (4) a determination of the existence of pneumoconiosis made by a physician exercising sound judgment, based upon certain clinical data and medical and work histories, and supported by a reasoned medical opinion.[15] 20 C.F.R. § 718.202(a)(4).

In *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 2000 WL 524798 (4th Cir. 2000), the Fourth Circuit held that the administrative law judge must weigh all evidence together under 20 C.F.R. § 718.202(a) to determine whether the miner suffered from coal workers' pneumoconiosis. This is contrary to the Board's view that an administrative law judge may weigh the evidence under each subsection separately, i.e. X-ray evidence at § 718.202(a)(1) is weighed apart from the medical opinion evidence at § 718.202(a)(4). In so holding, the court cited to the Third Circuit's decision in *Penn Allegheny Coal co. v. Williams,* 114 F.3d 22, 24-25 (3d Cir. 1997) which requires the same analysis.

The claimant cannot establish pneumoconiosis under § 718.202(a)(3), as none of that sections presumptions are applicable to a living miner's claim field after January 1, 1982, with no evidence of complicated pneumoconiosis.

A finding of the existence of pneumoconiosis may be made with positive chest X-ray evidence. 20 C.F.R. § 718.202(a)(1). The correlation between "physiologic and radiographic abnormalities is poor" in cases involving CWP. "[W]here two or more X-ray reports are in conflict, in evaluating such X-ray reports, consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays." *Id.; Dixon v. North Camp Coal Co*., 8 B.L.R. 1-344 (1985)." (Emphasis added). (Fact one is Board-certified in internal medicine or

[15] In accordance with the Board's guidance, I find each medical opinion documented and reasoned, unless otherwise noted. *Collins v. J & L Steel,* 21 B.L.R. 1-182 (1999) *citing Trumbo v. Reading Anthracite Co.*, 17 B.L.R. 1-85 (1993); *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987); and, *Sterling Smokeless Coal Co. v. Akers*, 121 F.3d 438, 21 B.L.R. 2-269 (4th Cir. 1997). This is the case, because except as otherwise noted, they are "documented" (medical), i.e., the reports set forth the clinical findings, observations, facts, etc., on which the doctor has based his diagnosis and "reasoned" since the documentation supports the doctor's assessment of the miner's health.

highly published is not so equated). *Melnick v. Consolidation Coal Co. & Director, OWCP*, 16 B.L.R. 1-31 (1991) at 1-37. Readers who are Board-certified radiologists and/or B-readers are classified as the most qualified. The qualifications of a certified radiologist are at least comparable to if not superior to a physician certified as a B-reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-213 n.5 (1985).

The December 11, 2001 X-ray is the only X-ray evidence in the record. Dr. Ranavaya, a B-reader, interpreted the X-ray as positive for coal workers' pneumoconiosis. Thereafter, two dually qualified physicians interpreted the X-ray as negative for coal workers' pneumoconiosis. Additionally, Dr. Ranavaya listed the film quality as one. Both dually qualified physicians listed the film quality as being light with a classification of 3. Based on the physician qualifications and the majority readings being negative, I find the December 11, 2001 X-ray negative for coal workers' pneumoconiosis. As such, Claimant did not prove pneumoconiosis by X-ray evidence.

A determination of the existence of pneumoconiosis can be made if a physician, exercising sound medical judgment, based upon certain clinical data, medical and work histories and supported by a reasoned medical opinion, finds the miner suffers or suffered from pneumoconiosis, as defined in § 718.201, notwithstanding a negative X-ray. 20 C.F.R. § 718.202(a).

Medical reports which are based upon and supported by patient histories, a review of symptoms, and a physical examination constitute adequately documented medical pinions as contemplated by the Regulations. *Justice v. Director, OWCP*, 6 B.L.R. 1-1127 (1984). However, where the physician's report, although documented, fails to explain how the documentation supports its conclusions, an Administrative Law Judge may find the report is not a reasoned medical opinion. *Smith v. Eastern Coal Co.*, 6 B.L.R. 1-1130 (1984). A medical opinion shall not be considered sufficiently reasoned if the underlying objective medical data contradicts it.[16] *White v. Director, OWCP*, 6 B.L.R. 1-368 (1983).

Dr. Perper, a Board-certified pathologist, reviewed the miner's records and the histological slides of the lung. He provided a detailed review of the slides. Dr. Perper determined that Mr. Wells had simple coal workers' pneumoconiosis. He also found evidence of lung cancer, centrilobular emphysema, acute bronchopneumonia and sclerosis of intra-pulmonary blood vessels consistent with pulmonary hypertension and cor pulmonale. Dr. Perper opined that the miner's coal dust exposure caused, in part, his centrilobular emphysema and lung cancer. Dr. Perper also related the miner's smoking history to his emphysema and lung cancer. Drs. Castle, Naeye and Zaldivar disagreed with Dr. Perper's conclusion that coal dust exposure

[16] *Fields v. Director, OWCP*, 10 B.L.R. 1-19, 1-22 (1987). "A 'documented' (medical) report sets forth the clinical findings, observations, facts, etc., on which the doctor has based his diagnosis. A report is 'reasoned' if the documentation supports the doctor's assessment of the miner's health. *Fuller v. Gibraltor Coal Corp.*, 6 B.L.R. 1-1291 (1984)…" In *Cornett v. Benham Coal, Inc.,* 227 F.3d 569, Case No. 99-3469, 22 B.L.R. 2-107 (6th Cir. Sept. 7, 2000), the court held if a physician bases a finding of CWP only upon the miner's history of coal dust exposure and a positive X-ray, then the opinion should not count as a reasoned medical opinion, under 20 C.F.R. § 718.202(a)(4). (It also rejected Dr. Fino's opinion that the miner's affliction was due solely to smoking and not coal dust exposure because the PFS were not consistent with fibrosis, as would be expected in simple CWP. Fibrosis, while an element of medical CWP, is not a required element of legal CWP).

caused the miner's lung cancer. Additionally, Drs. Naeye and Zaldivar disagreed with Dr. Perper's determination that coal dust exposure caused centrilobular emphysema.

I find Dr. Perper's diagnosis of medical simple coal workers' pneumoconiosis is reasoned and supported by objective evidence in the record. I further find that Dr. Perper provided a detailed explanation of the effect of both the miner's coal dust exposure and extensive smoking history on his pulmonary disease. However, based on the physician opinions of record, I find Dr. Perper's diagnosis of legal pneumoconiosis unreasoned. Dr. Perper did not provide persuasive evidence that coal dust exposure caused lung cancer and centrilobular emphysema. Thus, although I find Dr. Perper's determination of medical coal workers' pneumoconiosis reasoned, I find that his overall opinion lacks credibility.

Dr. Naeye, a Board-certified pathologist, concluded that Mr. Wells did not have coal workers' pneumoconiosis. He reviewed the medical records and the autopsy slides. Dr. Naeye found squamous cell carcinoma, massive acute lobular pneumonia, and very severe chronic bronchitis. Dr. Naeye clarified that the miner's life-long smoking habit caused the chronic bronchitis. Dr. Naeye adequately explained that his diagnosis of no pneumoconiosis may differ from radiological findings of pneumoconiosis because a better examination is possible when lung tissue is available for review. Dr. Naeye criticized Dr. Perper for not mentioning the size of the birefringent silica crystals he found and for relating coal dust exposure to lung cancer and centrilobular emphysema. Dr. Naeye attributed the fibrosis to the therapy the miner received for his lung cancer and noted that such birefringent crystals were too large to be fibrogenic. Dr. Naeye did not find any coal dust related disability. The impairments found by Dr. Naeye were related to the miner's extensive smoking history. I find that Dr. Naeye provided a detailed and reasoned opinion. Furthermore, I find that Dr. Naeye provided persuasive rebuttal arguments to the radiological findings of pneumoconiosis and to Dr. Perper's conclusions. Thus, I accord more weight to Dr. Naeye's opinion than to Dr. Perper's opinion.

Dr. Zaldivar, a Board-certified pulmonologist, concluded the miner had coal workers' pneumoconiosis. Dr. Zaldivar based his conclusion on his 1985 and 1990 examinations of Mr. Wells and a review of the medical records. Dr. Zaldivar reviewed Dr. Perper's report prior to his deposition. He did not appear to review any reports by Dr. Naeye. Dr. Zaldivar opined that the miner had radiological evidence coal workers' pneumoconiosis. As noted above, he disagreed with Dr. Perper's conclusion that coal dust exposure caused the miner's centrilobular emphysema and lung cancer. I find that Dr. Zaldivar provided a reasoned analysis of the medical evidence he received. I find Dr. Zaldivar's opinion more credible than Dr. Perper's opinion. However, I find Dr. Naeye's analysis of the pathological evidence more persuasive evidence than Dr. Zaldivar's analysis of the evidence.

Dr. Castle, Board-certified in internal medicine and pulmonary disease, provided two medical opinions and testified at a deposition. In his July 23, 2003 opinion, Dr. Castle found radiographic evidence of simple coal workers' pneumoconiosis. Thereafter, on December 16, 2003, at a deposition, Dr. Castle testified that Mr. Wells did not have pathologic evidence of coal workers' pneumoconiosis. In his second report, dated July 16, 2004, Dr. Castle stated that Mr. Wells had radiographic and pathologic evidence of simple coal workers' pneumoconiosis. Dr. Castle makes no mention of this deposition testimony in the July 16, 2004 report. Thus, it is unclear if, after further review, Dr. Castle is again changing his conclusion regarding whether or

not Mr. Wells has pneumoconiosis. Based on his inconsistent conclusions regarding a diagnosis of pneumoconiosis, I find that his conclusion is equivocal regarding pneumoconiosis and, thus, entitled to little weight.

Dr. Ranavaya, a B-reader, examined Mr. Wells in 2001. Dr. Ranavaya diagnosed Mr. Wells with pneumoconiosis, right lung cancer, coronary artery disease, and hypertension. He based his finding of pneumoconiosis on occupational exposure to coal dust and radiological evidence of coal workers' pneumoconiosis. Dr. Ranavaya noted that the miner had a 50-year smoking history. However, after noting such smoking history, Dr. Ranavaya made no further statements regarding the effect, if any, of such an extensive smoking history on the miner's pulmonary impairment. Dr. Ranavaya stated that he diagnosed lung cancer based on the miner's history and radiological evidence. I find Dr. Ranavaya's diagnosis of coal workers' pneumoconiosis reasoned and supported by objective evidence. However, I find that Drs. Castle, Naeye, Perper and Zaldivar provided more detailed and thorough opinions than Dr. Ranavaya. Furthermore, I find the pathological evidence relied upon by the other physicians more persuasive than Dr. Ranavaya's examination evidence.

In summary, I find the X-ray evidence is negative for coal workers' pneumoconiosis. I find Dr. Naeye's review of the autopsy slides the most persuasive evidence. Based on the above analysis, I accord more weight to the opinions of Drs. Naeye and Zaldivar over Drs. Castle, Perper and Ranavaya. I accord little weight to the death certificate and the Logan General Hospital records. Although the hospital records and the death certificate list pneumoconiosis as a condition, it is not clear how such diagnosis was determined.

Based on the X-ray evidence, physician opinions, death certificate and hospital records submitted since the final denial of the previous claim, I find the claimant has not met her burden of proof in establishing the existence of pneumoconiosis. *Director, OWCP v. Greenwich Collieries*, 512 U.S. 267, 114 S.Ct. 2251, 129 L.Ed.2d 221 (1994) *aff'g sub. nom. Greenwich Collieries v. Director, OWCP,* 990 F.2d 730, 17 B.L.R. 2-64 (3d Cir. 1993).

C. Cause of Pneumoconiosis

Once the miner is found to have pneumoconiosis, he must show that it arose, at least in part, out of coal mine employment. 20 C.F.R. § 718.203(a). If a miner who is suffering from pneumoconiosis was employed for ten years or more in the coal mines, there is a rebuttable presumption that the pneumoconiosis arose out of such employment. 20 C.F.R § 718.203(b). If a miner who is suffering or suffered from pneumoconiosis was employed less than ten years in the nation's coal mines, it shall be determined that such pneumoconiosis arose out of coal mine employment only if competent evidence establishes such a relationship. 20 C.F.R. § 718.203(c).

Since the miner had ten years or more of coal mine employment, the claimant would ordinarily receive the benefit of the rebuttable presumption that the miner's pneumoconiosis arose out of coal mine employment. However, in view of my finding that the existence of CWP has not been proven the issue is moot. Moreover, the presumption is rebutted by the medical opinion evidence discussed herein.

D. Existence of total disability due to pneumoconiosis

The claimant must show his total pulmonary disability is caused by pneumoconiosis. 20 C.F.R. § 718.204(b).[17] Section 718.204(b)(2)(i) through (b)(2)(iv) set forth criteria to establish total disability: (i) pulmonary function studies with qualifying values; (ii) blood gas studies with qualifying values; (iii) evidence that miner has pneumoconiosis and suffers from cor pulmonale with right-side congestive heart failure; (iv) reasoned medical opinions concluding the miner's respiratory or pulmonary condition prevents him from engaging in his usual coal mine employment; and lay testimony. Under this subsection, the Administrative Law Judge must consider all the evidence of record and determine whether the record contains "contrary probative evidence." If it does, the Administrative Law Judge must assign this evidence appropriate weight and determine "whether it outweighs the evidence supportive of a finding of total respiratory disability." *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-21 (1987); *see also Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195, 1-198 (1986), *aff'd on reconsideration en banc*, 9 B.L.R. 1-236 (1987).

Section 718.204(b)(2)(iii) is not applicable because there is no evidence that the claimant suffers from cor pulmonale with right-sided congestive heart failure.[18] § 718.204(d) is not applicable because it only applies to a survivor's claim or deceased miners' claim in the absence of medical or other relevant evidence.

Section 718.204(b)(2)(i) provides that a pulmonary function test may establish total disability if its values are equal to or less than those listed in Appendix B of Part 718.

The evidence includes a pulmonary function study performed by Dr. Ranavaya on December 11, 2001. The study did not produce qualifying results. Thus, the claimant did not prove total disability by a pulmonary function study.

Claimants may also demonstrate total disability due to pneumoconiosis based on the results of arterial blood gas studies that evidence an impairment in the transfer of oxygen and carbon dioxide between the lung alveoli and the blood stream. § 718.204(b)(2)(ii).

Dr. Ranavaya also performed an arterial blood gas study on December 11, 2001. This study did not produce qualifying results. Thus, the Claimant did not prove total disability by an arterial blood gas study.

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[17] § 718.204 (Effective Jan. 19, 2001). Total disability and disability causation defined; criteria for determining total disability and total disability due to pneumoconiosis, states: (a) General. Benefits are provided under the Act for or on behalf of miners who are totally disabled due to pneumoconiosis, or who were totally disabled due to pneumoconiosis at the time of death. For purposes of this section, any nonpulmonary or nonrespiratory condition or disease, which causes an independent disability unrelated to the miner's pulmonary or respiratory disability, shall not be considered in determining whether a miner is totally disabled due to pneumoconiosis. If, however, a nonpulmonary or nonrespiratory condition or disease shall be considered in determining whether a miner is or was totally disabled due to pneumoconiosis.

[18] As part of his diagnosis, Dr. Perper lists "sclerosis of intra-pulmonary blood vessels consistent with pulmonary hypertension and cor pulmonale." Dr. Perper makes no further mention of this, nor does any other doctor address the issue. Thus, I find that there is no evidence that the miner suffered from cor pulmonale with congestive heart failure.

Finally, total disability may be demonstrated, under § 718.204(b)(2)(iv), if a physician, exercising reasoned medial judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition presents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable or gainful work. § 718.204(b). Under this subsection, "…all the evidence relevant to the question of total disability due to pneumoconiosis is to be weighed, with the claimant bearing the burden of establishing, by a preponderance of the evidence, the existence of this element." *Mazgaj v. Valley Coal Company*, 9 B.L.R. 1-201 (1986) at 1-204. The fact finder must compare the exertional requirements of the claimant's usual coal mine employment with a physician's assessment of the claimant's respiratory impairment. *Schetroma v. Director, OWCP,* 18 B.L.R. 1-19 (1993). Once it is demonstrated that the miner is unable to perform his usual coal mine work a *prima facie* finding of total disability is made and the burden of going forward with evidence to prove the claimant is able to perform gainful and comparable work falls upon the party opposing entitlement, as defined pursuant to 20 C.F.R. § 718.204(b)(2). *Taylor v. Evans & Gambrel Co.*, 12 B.L.R. 1-83 (1988).

Dr. Perper concluded that the miner's coal workers' pneumoconiosis was a substantially contributory cause of his death. He determined that the coal workers' pneumoconiosis, the centrilobular emphysema and the lung cancer were combined causes of death. At his deposition, Dr. Perper testified that a combination of the legal and medical coal workers' pneumoconiosis was disabling. He further stated that the severity of the medical coal workers' pneumoconiosis was disabling by itself. Dr. Perper, however, went on to testify that he was asked to evaluate whether coal workers' pneumoconiosis contributed to the miner's death and, thus, did not form an opinion as to the degree of lifetime impairment. I find that Dr. Perper's opinion that the miner's medical coal workers' pneumoconiosis is totally disabling is not supported by the evidence of record. I further find Dr. Perper's opinion unclear in that he testifies regarding total disability during the miner's lifetime, then goes on to state that he did not form an opinion regarding the degree of lifetime impairment. I find that the overall inconsistencies and refutable theories presented by Dr. Perper hinder the credibility of his opinion. Thus, I find Dr. Perper's opinion is entitled to little weight.

Dr. Naeye determined that pneumoconiosis could not have caused the miner's death or any lifetime impairment. I find that Dr. Naeye provided a reasoned opinion based on his review of the medical evidence and autopsy slides.

Dr. Zaldivar found coal workers' pneumoconiosis and concluded that the miner's minimal respiratory impairment was of no clinical significance. He further opined that, prior to his death, the miner had the pulmonary capacity to perform his usual coal mine work. At his deposition, Dr. Zaldivar testified that at the time of the 2003 report, the miner had a disability due to cancer, but did not have any impairment. He did not discuss the level of disability. Moreover, Dr. Zaldivar did not have any evidence immediately preceding the miner's death and, thus, could not make a determination of total disability prior to death. Based on his statement that he lacked the medical evidence in the year preceding his death, I find that Dr. Zaldivar's opinion neither precludes nor establishes a finding of total disability.

Dr. Castle noted a very minimal degree of airway obstruction. He concluded the miner was not permanently and totally disabled. Dr. Castle did not find a disabling abnormality from

any cause. He testified that, prior to his death, Mr. Wells had the respiratory capacity to perform his usual coal mine work. He went on to state that Mr. Wells was disabled as a "whole man" due to lung cancer. Dr. Castle determined that lung cancer caused the miner's death. I find that Dr. Castle's statement that Mr. Wells was disabled as a "whole man" does not support a finding of total disability. It is unclear if Dr. Castle's "whole man" terminology implies that he equates such a term with total disability. Thus, I find that Dr. Castle's opinion does not support a finding of total disability.

Dr. Ranavaya examined Mr. Wells in 2001. Dr. Ranavaya concluded that the miner had a minimal impairment which would not have prevented him from performing his prior coal mine employment. I find that Dr. Ranavaya's opinion is reasoned and supported by the objective evidence obtained at his examination of the miner.

In summary, I find that Dr. Perper's opinion is entitled to little weight and that the opinions of Drs. Naeye, Zaldivar, Castle and Ranavaya do not support a finding of total disability.

Based on the pulmonary function study, arterial blood gas study and physician opinions, I find the claimant has not met her burden of proof in establishing the existence of total disability. *Director, OWCP v. Greenwich Collieries [Ondecko]*, 512 U.S. 267, 114 S.Ct. 2251, 129 L.Ed.2d 221 (1994), *aff'g sub. Nom. Greenwich Colleries v. Director, OWCP*, 990 F.2d 730, 17 B.L.R. 2-64 (3d Cir. 1993).

E. Cause of total disability

Since I have found that the evidence of record fails to establish that Mr. Wells had (clinical or legal) pneumoconiosis and fails to establish that he suffered from a total respiratory disability, I accordingly find that the claimant failed to establish that the miner suffered from a total respiratory disability due to clinical or legal pneumoconiosis.

ATTORNEY FEES

The award of attorney's fees, under the Act, is permitted only in cases in which the claimant is found to be entitled to the receipt of benefits. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the claimant for the representation services rendered to him in pursuit of the claim.

CONCLUSIONS

In conclusion, the claimant has not established that a material change in condition has taken place since the previous denial. The miner did not have pneumoconiosis, as defined by the Act and Regulations. The miner was not totally disabled. Thus, he was not totally disabled due to pneumoconiosis. The Claimant is therefore not entitled to benefits.

ORDER[19]

It is ordered that the claim of Daley Wells on behalf of James F. Wells for benefits under the Black Lung Benefits Act is hereby DENIED.

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RICHARD A. MORGAN
Administrative Law Judge

NOTICE OF APPEAL RIGHTS (**Effective Jan. 19, 2001**): Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board before the decision becomes final, i.e., at the expiration of thirty (30) days after "filing" (or **receipt by**) with the Division of Coal Mine Workers' Compensation, OWCP, ESA, ("DCMWC"), by filing a Notice of Appeal with the **Benefits Review Board, ATTN: Clerk of the Board, P.O. Box 37601, Washington, D.C. 20013-7601.**[20]

[19] § 725.478 Filing and service of decision and order (Change effective Jan. 19, 2001). Upon receipt of a decision and order by the DCMWC, the decision and order shall be considered to be filed in the office of the district director, and shall become effective on that date.

[20] 20 C.F.R. § 725.479 (Change effective Jan. 19, 2001). (d) Regardless of any defect in service, **actual receipt** of the decision is sufficient to commence the 30-day period for requesting reconsideration or appealing the decision.